# STAFF WORK ADVISORY TEAM
# QUESTIONS AND ANSWERS REGARDING
# CLAIMING AND BILLING

(Updated 10-03)

**Q1. Do staff claim travel and documentation time at whatever service function rate, e.g., Mental Health Service (MHS), Case Management, etc., of the service provided?**

*A1. Yes. Travel and documentation time must be linked to the service provided.*

**Q2. Can staff claim Federal Financial Participation (FFP) for case management services provided while a beneficiary is in an IMD?**

*A2. FFP cannot be claimed if the beneficiary is between the ages of 21-64.*

*Yes, if the beneficiary is 65 or older. Yes, if the beneficiary is under 21 and is a patient in a hospital or another accredited facility. (Contact the chief of the Managed Care Implementation unit for information about the possibility of accrediting facilities other than hospitals.)*

**Q3. Can staff claim FFP for transporting beneficiaries to mental health appointments as a specialty mental health service?**

*A3. No. Transportation is not reimbursable as a specialty mental health service. However, the cost of transportation services can be included in determining the cost of delivering specialty mental health services.*

**Q4. Can staff claim FFP for a parenting group that includes parents whose children have open cases at the clinic?**

*A4. Yes, if the services are directed at the mental health needs of the children, rather than based upon the needs of the parents. In addition, there must be documentation in the child's chart to show the need for this activity.*

**Q5. Can FFP be claimed for assisting beneficiaries to obtain their medication by preparing an authorization request?**

*A5. Yes, FFP can be claimed for completing an authorization request for a prescription as it relates to the provision of medication support services. Only physicians, RNs, LVNs, psychiatric technicians, or pharmacists within their scopes of practice may provide medication support services.*

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**Q6. Can staff claim FFP for photocopying, faxing, and other clerical type activities as specialty mental health services?**

*A6. No. However, the cost of such activities can be included in determining the cost of delivering specialty mental health services.*

**Q7. Can staff claim FFP for payee related activities?**

*A7. FFP cannot be claimed for time spent performing the fiscal responsibilities of a payee. For example, staff cannot claim FFP for time spent writing checks to pay the beneficiary's bills.*

*However, it is possible to claim for payee related services when such activities are necessary to address impairment in an important area of life functioning. For example, staff can claim FFP for time spent providing training on money management skills.*

***Q8.*** **Can staff claim FFP for telephone assessments?**

*A8. Yes. Assessments can be completed face-to-face or over the telephone. However, MHPs are strongly encouraged to complete face-to-face assessments when determining medical necessity.*

**Q9. How long can staff claim FFP for services provided after a beneficiary has died?**

*A9. All services claimed to Medi-Cal on behalf of a beneficiary must be provided to meet the mental health needs of that beneficiary. Therefore, FFP can not to be claimed for any services provided once the beneficiary has died. In addition, claims must be submitted in a timely fashion as specified in Title 9.*

**Q10. Can staff claim FFP for court related assessments, e.g., conservatorship investigations?**

*A10. Yes, when the assessment is completed for clinical, treatment-related purposes. For example, FFP can be claimed if the purpose of a court-ordered assessment is to determine medical necessity for Medi-Cal.*

*No, if the assessment is completed per request of the court for a purpose other than determining medical necessity for Medi-Cal. For example, FFP cannot be claimed if a court-ordered assessment is narrowly defined for establishment of conservatorship and the MHP limits its assessment to this purpose.*

*Please note that the use of realignment dollars is limited in this area, as well as the use of Medi-Cal dollars. See Welfare and Institutions Code (W&IC) Section 5714 below.*

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***W&IC Section 5714**. To continue county expenditures for legal proceedings involving mentally disordered persons, the following costs incurred in carrying out Part 1 (commencing with Section 5000—LPS Act) of this division shall not be paid for from funds designated for mental health services.*

*(a) The costs involved in bringing a person in for 72-hour treatment and evaluation.*

*(b) The costs of court proceedings for court-ordered evaluation, including the service of the court order and the apprehension of the person ordered to evaluation when necessary.*

*(c) The costs of court proceedings in cases of appeal from 14-day intensive treatment.*

*(d) The cost of legal proceedings in conservatorship other than the costs of conservatorship investigation as defined by regulations of the State Department of Mental Health.*

*(e) The court costs in post certification proceedings.*

*(f) The cost of providing a public defender or other court-appointed attorneys in proceedings for those unable to pay.*

**Q11. What are the current 24-hour claiming limitations listed by service type?**

*A11. California Code of Regulations (CCR), Title 9, Chapter 11, Section 1840.366(b) specifies: "The maximum amount claimable for Crisis Intervention in a 24-hour period is 8 hours."*

*CCR, Title 9, Chapter 11, Section 1840.368(c) specifies: "The maximum number of hours claimable for Crisis Stabilization in a 24-hour period is 20 hours."*

*CCR, Title 9, Chapter 11, Section 1840.372 specifies: "The maximum amount claimable for Medication Support Services in a 24-hour period is 4 hours."*

**Q12. Regarding medication support services, can staff claim FFP for medication support services in a group setting as long as the following conditions are met:**

- **Time is prorated per CCR, Title 9, Chapter 11, Section 1840.316(a)(2), and**
- **The medication support services provided meets the definition of medication support services in CCR, Title 9, Chapter 11, Section 1810.225, and**
- **The service is provided by staff who are qualified to provide such services?**

*A12. Yes, as in the following example:*

*An R.N. facilitates a weekly group discussion on medication education, e.g., the side effects of the medication, overcoming resistance to taking medications, etc. This intervention and its goals should be addressed in each individual's client plan.*

**Q13. Are there any special lockouts on claiming FFP while a beneficiary is in Rate Classification Level (RCL) 12-14 facilities (group homes that specialize in serving children with mental illness)?**

*A13. There are no special lockouts outside those listed in Title 9 while a beneficiary resides in RCL 12-14 facilities because the RCL 12-14 rates do not include treatment services. The duplicate payment issues that exist when a beneficiary is in a 24-hour facility that is receiving reimbursement for treatment services do not exist when the beneficiary is in an RCL 12-14 facility.*

**Q14. When a treatment group contains both Medi-Cal and non Medi-Cal clients, how is staff to divide the time? For example, if a group of six clients containing three Medi-Cal and three non-Medi-Cal clients lasts 120 minutes (group time plus documentation), how is the time divided? By three or by six?**

*A14. The time must be divided equally among all six clients.*

**Q15. Can FFP be claimed for travel time from one provider site to another provider site? How about from a staff person's residence to a provider site? Or from a staff's home to a client's home?**

*A15. To claim FFP, travel time must be from a provider site to an off-site location(s) where Medi-Cal specialty mental health services are delivered. Therefore, FFP cannot be claimed for travel between provider sites or from a staff member's residence to a provider site.*

*NOTE: A "provider site" is defined as a site with a provider number, including affiliated satellite and school site operations.*

*It is possible to claim for travel time between a staff's home and the client's home as long as the MHP permits such activity and MHP travel guidelines are adhered to.*

**Q16. Can staff claim FFP for a specialty mental health service, other than the assessment(s) to establish medical necessity, prior to establishing medical necessity?**

A16. Yes, but only if the service is related to an urgent/crisis situation.

**Q17. How do staff claim time when services with two different rates are provided during the course of a client session, e.g., 30 minutes of mental health services and 30 minutes of case management? Does the staff claim the whole time to the dominant service**

**provided, or claim 30 minutes to mental health services and 30 minutes to case management?**

**Can staff write one progress note and break out the claim by each service, or must a separate progress note be written for each service?**

*A17. In the above situation, staff should claim for each service separately or claim the entire time to the lower cost center, e.g., case management. Staff may write two separate progress notes or write one progress note that clearly delineates the time spent providing each service. While it is not required that staff document the actual number of minutes claimed in each progress note, a clear audit trail must still be maintained, including documentation of actual minutes using the forms and/or procedures established by the MHP or provider.*

**Q18. When does an MHP have to disallow claims?**

*A18. There is no specific Title 9 regulation or DMH/MHP contract provision that requires MHPs to disallow claims. MHPs, however, are to operate their programs in compliance with federal and state laws and regulations governing the Medi-Cal program and the terms of their contracts. Oversight of staff and contract performance that includes the possibility of disallowance is one method for meeting this responsibility.*

*DMH has established criteria for disallowance of claims for use in its annual reviews of the MHPs. The DMH reviews the disallowance criteria annually and makes revisions as needed. Updates to disallowance criteria are posted on the DMH website and in the Annual Review Protocol for Consolidated Specialty Mental Health Services and Other Funded Services. For fiscal year 2002-03, the DMH uses the following criteria to disallow non-hospital claims:*

- *Documentation in the chart does not establish that the beneficiary has a diagnosis contained in Section 1830.205(b)(1)(A-R).*
- *Documentation in the chart does not establish that, as a result of a mental disorder listed in Section 1830.205(b)(1)(A-R), the beneficiary has, at least, one of the following impairments:*
    - *A significant impairment in an important area of life functioning*
    - *A probability of significant deterioration in an important area of life functioning*
    - *A probability the child will not progress developmentally as individually appropriate*
    - *(For beneficiaries under the age of 21 years) A defect or mental illness that specialty mental health services can correct or ameliorate*

*MHPs may follow these criteria for disallowing claims, but may also establish additional, reasonable criteria for disallowing claims and specify them in their provider contracts.*

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**Q19. Can an MHP charge Medi-Cal beneficiaries a co-payment?**

*A19. California Code of Regulations, Title 9, Section 1810.365, "Beneficiary Billing," specifies situations when an MHP can collect reimbursement from a beneficiary:*

1) *Other health insurance,*
2) *Medi-Cal Share-of-Cost,*
3) *Co-payments in accordance with Welfare and Institutions Code (W&IC) Section 14134 (see below)*

*W&IC Section 14134 allows the MHP to collect a co-payment, generally $1.00 per outpatient visit, as long as no beneficiary is denied services because the co-payment is not collected. W&IC Section 14134 also lists specific beneficiaries who may not be charged a co-payment, including beneficiaries who are 18 years of age or younger or who are inpatients in hospitals or psychiatric health facilities. The MHP must ensure that any system established to collect co-payments is in compliance with the limits of W&IC Section 14134. The MHP may also wish to perform a cost analysis before embarking on such a venture.*

***W&IC 14134**. Except for any prescription, refill, visit, service, device, or item for which the program's payment is ten dollars ($10) or less, in which case no copayment shall be required, a recipient of services under this chapter shall be required to make copayments not to exceed the maximum permitted under federal regulations or federal waivers as follows:*

*(a) Copayment of five dollars ($5) shall be made for nonemergency services received in an emergency room. For the purposes of this section, "nonemergency services" means any services not required for the alleviation of severe pain or the immediate diagnosis and treatment of severe medical conditions which, if not immediately diagnosed and treated, would lead to disability or death.*

*(b) Copayment of one dollar ($1) shall be made for each drug prescription or refill.*

*(c) Copayment of one dollar ($1) shall be made for each visit for services under subdivisions (a) and (h) of Section 14132.*

*(d) The copayment amounts set forth in subdivisions (a), (b), and (c) may be collected and retained or waived by the provider.*

*(e) The department shall not reduce the reimbursement otherwise due to providers as a result of the copayment. The copayment amounts shall be in addition to any reimbursement otherwise due the provider for services rendered under this program.*

*(f) This section does not apply to emergency services, family planning services, or to any services received by:*
*(1) Any child in AFDC-Foster Care, as defined in Section 11400.*
*(2) Any person who is an inpatient in a health facility, as defined in Section 1250 of the Health and Safety Code.*

*(3) Any person 18 years of age or under.*
*(4) Any woman receiving perinatal care.*

*(g) Subdivision (b) does not apply to any person 65 years of age or over.*

*(h) A provider of service shall not deny care or services to an individual solely because of that person's inability to copay under this section. An individual shall, however, remain liable to the provider for any copayment amount owed.*

**Q20. When can FFP be claimed for treating undocumented aliens?**

*A20. The MHP needs to deliver services to beneficiaries who are undocumented aliens based on what is covered by the beneficiaries' aid category. Undocumented aliens are eligible for aid categories that cover emergency and/or pregnancy services only. The MHP would be responsible only after the eligibility had been determined. (For more information, check aid code listings available at https://mhhitws.ca.gov/reference_information.asp)*

*Title 9, California Code of Regulations (CCR), Section 1810.216 says: "'Emergency Psychiatric Condition' means a condition that meets the criteria in Section 1820.205 when the beneficiary with the condition, due to a mental disorder, is a danger to self or others, or immediately unable to provide for or utilize, food, shelter or clothing, and requires psychiatric inpatient hospital or psychiatric health facility services."*

*What this means is that only emergency psychiatric inpatient hospital services and related psychiatric inpatient hospital professional services are covered for Medi-Cal beneficiaries who are only covered for emergency services. Crisis intervention and crisis stabilization are not emergency services under the Medi-Cal managed mental health care program.*

*Pregnancy-related services, when covered, are broader than emergency services. These services involve treatment of a mental illness that might affect the outcome of the pregnancy.*

**Q21. If a patient is admitted to an acute care setting for a medical condition, what specialty mental health services are eligible for FFP?**

*A21. Title 9, CCR, Section 1840.215 and Sections 1840.360 through 1840.374 only address lock-out requirements for specialty mental health services. There is nothing in the regulations that prohibits claiming FFP for the provision of medically necessary specialty mental health services while a beneficiary is on a medical unit. Since the per diem rates for Medi-Cal inpatient hospital services do cover routine hospital services and hospital based ancillary services, however, only specialty mental health that are clearly **not** routine hospital services or hospital based ancillary services may be separately reimbursed by Medi-Cal. Psychotherapy and medication support services by psychiatrists are not only eligible for FFP, but must be delivered if medically necessary. Other services should be evaluated to determine whether or not they would be considered routine hospital services or hospital-based ancillary services if*

*provided as a part of a psychiatric inpatient hospital service. MHPs may decide who provides such services and whether or not authorization is required prior to providing the services.*

**Q22. Can FFP be claimed for administrative hospital days if FFP was not claimed for the days of acute status? For example, a patient who meets medical necessity criteria but is ineligible for Medi-Cal because of his/her legal status, e.g., in jail custody. The court later releases him/her, but the patient remains in the hospital pending suitable placement.**

*A22. Yes, as long as medical necessity for acute psychiatric inpatient hospital services had been established at some point during the patient's stay in the hospital.*

**Q23. What are the rules around claiming FFP for services provided by students, volunteers, and paid consumers?**

*A23. Generally: 1) A "student" is someone who is in school in a social work, counseling, or related school placement program at a provider site and includes both undergraduate and graduate students. 2) A "volunteer" is someone who is not "employed" by the provider, for example, a person accumulating qualifying hours to become licensed, and works without pay. 3) A "paid consumer" is someone who is a consumer and who is employed by the provider, typically to provide peer support and interaction to the provider's clients.*

*As long as all Medi-Cal requirements and any supervision and scope of practice requirements are met, MHPs and its providers may claim FFP for Medi-Cal services provided by students, volunteers, and paid consumers. Please be aware, however, that these units of services must be counted when determining unit costs and that only the actual amounts paid to the students, volunteers, and paid consumers may be included in the cost report (e.g., zero dollars for a volunteer).*